

**National Centre
for Healthy Ageing**

A partnership between



MONASH
University



**Peninsula
Health**

Healthy Ageing Data Platform

Core Data items – High level Data Dictionary Dec 2025

The data items detailed in this document form the Core Data items for the NCHA Data Platform. Other non-core data items may be available. Please contact the Data Platform to discuss your requirements. Email: nchadataaccess@monash.edu



National Centre for Healthy Ageing (NCHA) Data Platform - Demographic Core Data Items

NOTE: The 'Special' core data item will require justification for data access

Core Data Item	Definition	Rationale	Core Data item type	Number of available drop down options	Example Data
Sex	The sex of the person	Standard demographic item for service analysis / risk adjustment Verify diagnosis / procedure codes	Routine	6	<i>Male</i>
Date of Birth (MM,YYYY)	Month and year of birth of the person.	Standard demographic item for deriving age for service analysis / risk adjustment Verify diagnosis / procedure codes	Routine	N/A	<i>08,1920</i>
Postcode	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a party (person or organisation), as defined by Australia Post.	To determine Statistical Local Area (SLA) and to derive socio-economic disadvantage (SEIFA) and metro/regional for model adjustment and cohort identification.	Routine	>2000	<i>3000</i>
Interpreter requirement	Flag to determine whether Patient requires an interpreter	To determine which type of patient received the interpretation services.	Routine	2	<i>1</i>
Country of Birth	The country in which the person was born.	To identify any increased risk for specific diseases or barriers to health service access	Routine	>300	<i>Australia</i>
Marital Status	A person's current relationship status in terms of a couple relationship, or, for those not in a couple relationship, the existence of a current or previous registered marriage, as represented by a code.	To determine availability of social support system to access health care services, and use of services.	Routine	>10	<i>Single</i>
Living Arrangement	Whether the person usually resides alone or with others	To understand the potential resources available to the person for health resource planning.	Routine	6	<i>Lives with family</i>
Usual Accommodation Type	The type of accommodation in which the person usually lives	To understand whether care-giving services are being provided where the patient lives e.g. community vs residential or supported care	Routine	>30	<i>Living with others</i>

National Centre for Healthy Ageing (NCHA) Data Platform - Emergency Core Data Items

NOTE: The 'Special' core data item will require justification for data access

Core Data Item	Definition	Rationale	Core Data item type	Number of available drop down options	Example Data
Arrival Date	Patient arrived date in emergency	To derive waiting times in order to better understand the patient flow in the Emergency Department.	Routine	N/A	3/08/2018
Primary Diagnosis	The diagnosis established at the conclusion of the patient's attendance in an emergency department to be mainly responsible for occasioning the attendance following consideration of clinical assessment, as represented by a code.	To facilitate epidemiological studies and other research such as understanding the diagnosis frequency and diagnostic accuracy studies.	Routine	>900	S7208 (for Fracture of Hip)
Additional Diagnoses	Additional diagnoses are those which: -Existed at the time of presentation -Arose while patient was in the Emergency Department Are expected to affect treatment plan or length of stay in the Emergency Department	To better understand the factors impacting length of stay, more intensive treatment or patient outcome. Additional diagnosis can include diseases, conditions, injuries, poisoning, signs, symptoms, abnormal findings, complaints or other factors influencing the patient's health status.	Routine	>900	S7208 (for Fracture of Hip)
Arrival Mode	The mode of transport by which the person arrives at the emergency department, as represented by a code.	To better understand implications of transport mode on triage and patient outcomes.	Routine	>10	Road Ambulance Service
Visit Type	The reason the patient presents to an emergency department.	To understand the appropriate use of the Emergency Department.	Routine	8	Emergency Presentation
Departure Date	Patient departed date from emergency	To derive waiting times in order to better understand the patient flow in the Emergency Department and to identify the subsequent admission.	Routine	N/A	3/08/2018
Departure Destination	Patient destination or status on departure from the Emergency Department.	To understand the relationship between multiple ED presentations, readmissions and the status or location of patients on departure from the ED.	Routine	>20	Left after clinical advice regarding treatment options
Time to triage	Time to triage (in minutes) is the difference between Arrival date/time and triage date/time.	To derive waiting times in order to better understand the patient flow in the Emergency Department.	Routine	N/A	54
Triage Category	The urgency of the patient's need for medical and nursing care as assessed at triage, as represented by a code.	For better determination of possible medical risks to optimise patient care and outcome.	Routine	7	Semi Urgent
Nature of Main Injury	The patho-physical nature of the injury primarily responsible for the patient's presentation at the Emergency Department	For facilitation of medical injury surveillance, understanding the impact on Length of Stay and injury rates.	Routine	>20	Crushing Injury
Injury Cause	Event, circumstances or condition associated with the occurrence of injury, poisoning or adverse effect.	To facilitate injury reasons research.	Routine	>30	Cutting, piercing object
Human Intent	Clinician's assessment of the most likely human intent in the occurrence of the injury or poisoning.	To better understand the relationship between human intent, patient care and planning for interventions.	Routine	>20	Intentional self-harm - non-suicidal self-injury

National Centre for Healthy Ageing (NCHA) Data Platform - Inpatient Episode of Care Core Data Items

NOTE: The 'Special' core data item will require justification for data access

Core Data Item	Definition	Rationale	Core Data item type	Number of available drop down options	Example Data
Admission Date	Date on which an admitted patient commences an episode of care	For cohort structuring and tracking care pathways Needed for calculating Length of Stay and Age.	Routine	N/A	3/08/2018
Primary Diagnosis Code	Principal diagnosis code (ICD-10-AM) reflecting injuries, disease conditions, patient characteristics and circumstances impacting this episode of care.	To identify episodes containing specified codes for the facilitation of research / epidemiological requirements. These codes will be further categorised into clinical groupings to allow identification of clinical cohorts, assess the quality of care delivered, determine what types of health problems are being seen and treated in the different types of ambulatory care facilities, and for assessing the appropriateness of the setting used to perform the services.	Routine	>4000	G309 (for Alzheimer's disease, unspecified)
Other Diagnosis Code/s	Other diagnosis codes (ICD-10-AM) reflecting injuries, disease conditions, patient characteristics and circumstances impacting the episode of care	To understand all conditions that coexist at the time of admission, or develop subsequently, which affect the treatment received and/or the length of stay i.e. comorbidities. Will also be used to develop severity and comorbidity indices for risk adjustment	Routine	>4000	F028 (for Dementia in other spec dis class elsewhere); R454(for Irritability and anger)
Primary Procedure Code	Principal procedure code (ICD-10-AM) reflecting the intervention used for the diagnosis and/or treatment of ill health during this episode of care	To identify episodes containing specified codes for the facilitation of research / epidemiological requirements. To assess the quality of care delivered, to determine what types of health problems are being seen and treated in the different types of ambulatory care facilities, and for assessing the appropriateness of the setting used to perform the services.	Routine	>4000	3849700 (for Coronary artery bypass, using 1 saphenous vein graft)
Other Procedure Code/s	Other ICD-10-AM procedure codes relevant to the episode of care	To understand all procedures that exists at the time of admission, or develop subsequently, which affect the treatment received and/or the length of stay. Also to develop severity indexes, comorbidities and assessing resource requirements and use.	Routine	>4000	3824100 (for Coronary artery blood flow measurement); 3830001 (for Open transluminal balloon angioplasty of 1 coronary artery)
Discharge Date	Date of separation at which patient completes an episode of care	For cohort structuring and tracking care pathways. Needed for calculating LOS and movement within the health service within a single stay	Routine	N/A	13/08/2018
Died During Episode	Died during the episode flag.	To better understand the preventable risks, possible interventions and association between the outcome and mortality.	Routine	N/A	0
Date of Death	The day and time at which it is determined or presumed that person has died.	Important outcome variable	Routine	N/A	13/08/2018
Admission Type	The category of admission relating to the episode of care	Allows distinguishing between episodes of planned and unplanned care	Routine	>10	Admission from ED; Statistical admission; Planned admission

National Centre for Healthy Ageing (NCHA) Data Platform - Inpatient Episode of Care Core Data Items

NOTE: The 'Special' core data item will require justification for data access

Core Data Item	Definition	Rationale	Core Data item type	Number of available drop down options	Example Data
Admitting Specialty	Unit/Specialty patient is admitted under	Allows to understand the outcome of patient admission in various specialities.	Routine	>100	<i>Cardiology; Gastroenterology; Rehabilitation, Inpatient (non-acute)</i>
Admission Care Type	Care type at time of admission	Allows to understand the outcome of patient admission in various care types.	Routine	>60	<i>Palliative Care; Acute, Aged Persons Mental Health (APMH)</i>
Discharging Specialty	Unit/Specialty at separation	Allows to understand the outcome of patient admission in various specialities.	Routine	>100	<i>Cardiology; Gastroenterology; Rehabilitation, Inpatient (non-acute)</i>
Discharge Destination	Status at separation of the person, and where applicable, place to which the person is released.	To determine any association between discharge destination with outcomes and readmissions.	Routine	>20	<i>Private residence /accommodation</i>
Intention to re-admit	The intention of the responsible clinician, at the time of the patient's separation from hospital, to re-admit the patient within 28 days	To understand the unplanned readmission rate vs planned readmission rate.	Routine	9	<i>No Plan to Re-admit within 28 days</i>
Onset Date	Date of admission for the acute episode of care, relating to the injury or disease condition, for which the person is now admitted for a subsequent rehabilitation episode of care.	To enable measurement of the time elapsed since the initial acute episode, to sub-acute episodes.	Routine	N/A	<i>8/08/2018</i>
Duration of stay in CCU	Total hours in an approved Cardiac/Coronary Care Unit (CCU)	To understand the relationship between length of stay in CCU and episode outcome including mortality.	Routine	N/A	<i>120</i>
Duration of stay in ICU	Total hours in an approved Intensive Care Unit (ICU)	To understand the relationship between length of stay in ICU and episode outcome including mortality.	Routine	N/A	<i>120</i>
Transfer Reason	Reason for Transfer	Can be used for understanding patient transfers and the resulting outcome.	Special	8	<i>ICU bed not available</i>
Systolic Blood Pressure	The blood pressure during the contraction of the left ventricle of the heart.	For predicting and monitoring clinical outcomes.	Special	N/A	<i>mmHg</i>
Diastolic Blood Pressure	The blood pressure after the contraction of the heart while the chambers of the heart refill with blood.	For predicting and monitoring clinical outcomes.	Special	N/A	<i>mmHg</i>
Pulse	The rate of the pulse as observed in an artery, expressed as beats per minute. It can be measured at several anatomical sites, including the wrist, neck, temple, groin, behind the knees, or on top of the foot.	For predicting and monitoring clinical outcomes.	Special	N/A	<i>number/minute</i>
Temperature	The temperature of the person.	For predicting and monitoring clinical outcomes.	Special	N/A	<i>Degrees Celsius</i>
Height	Height of the person	For predicting and monitoring clinical outcome.	Special	N/A	<i>cm</i>
Weight	Weight of patient at time of admission in grams.	For predicting and monitoring clinical outcomes.	Special	N/A	<i>Kg</i>
Body Mass Index	A measure of a person's weight (body mass) relative to height used to assess the extent of weight deficit or excess in adults and excess only in children and adolescents.	To understand the prevalence of any health risks such as coronary heart disease, diabetes, and high blood pressure.	Special	N/A	<i>Derived based on height and weight</i>
Date of Vital Signs taken	Date of vital signs taken and recorded	For predicting and monitoring clinical deterioration.	Special	N/A	<i>8/08/2018</i>

National Centre for Healthy Ageing (NCHA) Data Platform - Inpatient Episode of Care Core Data Items

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Core Data Item	Definition	Rationale	Core Data item type	Number of available drop down options	Example Data
Current Drug Overdose	Current Drug Overdose	To understand the impact of drug overdose on admissions, health status and possible readmissions	Special	N/A	<i>Current Drug Overdose</i>
Clinical Intervention	An intervention carried out to improve, maintain or assess the health of a person, in a clinical situation. Clinical interventions include invasive and non-invasive procedures, and cognitive interventions.	To understand whether any surgical or non-surgical interventions provided for improved patient care.	Special		<i>PT Upper limb interventions</i>
Tobacco Misuse	Tobacco misuse flag	To better understand related diagnoses and risk factors	Special	N/A	<i>Tobacco misuse</i>
Alcohol Misuse	Alcohol misuse flag	To better understand related diagnoses an risk factors	Special	N/A	<i>Alcohol misuse</i>
Cancer Diagnosis Date	The date when the cancer was first diagnosed (whether at its primary site or as a metastasis).	To better understand timing of treatment and outcomes.	Special	N/A	<i>3/08/2018</i>
Aged care assessment service status (ACAS)	Aged care assessment service status (ACAS)	For understanding the eligibility in accessing higher level services, including Commonwealth funded residential aged care, Home Care Packages, or residential respite care on the patient outcome.	Special	7	<i>Assessment incomplete - referral to Sub-acute services</i>
Functional Independence Measure (FIM) Score (as assessed on admission)	Functional Independence Measure (FIM) Score, as assessed on admission of the sub-acute episode of care only	To understand the physical and memory dependance of the patient, to understand the effectiveness of the rehabilitation	Special	N/A	35
Functional Independence Measure (FIM) Score (as assessed at discharge)	Functional Independence Measure (FIM) Score, as assessed at discharge of the sub-acute episode of care only	To understand the physical and memory dependance of the patient, to understand the effectiveness of the rehabilitation	Special	N/A	35

National Centre for Healthy Ageing (NCHA) Data Platform - Theatre/Surgical Core Data Items

NOTE: The 'Special' core data item will require justification for data access

Core Data Item	Definition	Rationale	Core Data item type	Number of available drop down options	Example Data
Theatre Case Specialty	The speciality of the theatre booking	For determination of associated risks impacting outcomes and improving model of care.	Routine	>100	<i>Cardiology; Orthopaedics</i>
Primary Procedure Code ID	The procedure for which the theatre booking is made	For determination of associated risks impacting outcomes and improving model of care.	Routine	>4000	<i>116674 (for Phalanx or metacarpal of the hand. osteotomy of. with internal fixation)</i>
Operation Type	The type of operation (not the operation itself)	For analysis of planned vs unplanned operations and the impact on outcome.	Routine	7	<i>Accident & Emergency</i>
Surgery Start Date	The date the surgery started	In deriving waiting period.	Routine	N/A	<i>3/08/2018</i>
Unplanned Return to Theatre	Indicates that the patient had an unplanned return to theatre	For determination of planned vs unplanned admissions in the determination of readmissions.	Special	N/A	<i>N</i>
Operation Outcome	The outcome of the operation	For better understanding outcomes.	Special	5	<i>Completed as planned</i>
ASA Score	The anaesthetist's score for the patient preoperatively	For risk assessment of possible outcome and interventions planning.	Special	>10	<i>3 - Patient with severe systemic disease</i>
Anaesthetic Type	The type of anaesthetic given to the patient for the case	For comparison of anaesthetic types and the implications on patient care.	Special	>30	<i>Nerve Block; Epidural</i>
Episode ID	The identifier of the episode This field is also populated for cancelled operations	Used in the total waiting time calculation.	Special	N/A	<i>12345</i>
Theatre Case ID	Case Identification Number	For identification of the theatre case with the determination of readmissions and other surgical data research.	Special	N/A	<i>107919</i>

National Centre for Healthy Ageing (NCHA) Data Platform - Outpatient Core Data Items

NOTE: The 'Special' core data item will require justification for data access

Core Data Item	Definition	Rationale	Core Data item type	Number of available drop down options	Example Data
Episode Start Date	When a program/stream first accepts a patient/client. This occurs in response to a referral, when a referral is accepted.	To facilitate cross sectional studies, to understand continuity of care and patient outcomes	Routine	N/A	3/08/2018
Episode Program/Stream	The program/stream to which the patient's/client's episode relates.	To facilitate cross sectional studies, to understand continuity of care and patient outcomes	Routine	>30	312 (for Wound care)
Episode Health Conditions	An indication of the health condition or diagnosis contributing to the reason for providing a program/stream, and any additional health condition(s) that impact on the episode.	To facilitate cross sectional studies, to understand continuity of care and patient outcomes	Routine	>80	A83 (for Post pelvic fracture)
Episode other factors affecting health	An indication of the other factors affecting health to accurately reflect the complexity of patients/clients.	To facilitate cross sectional studies, to understand continuity of care and patient outcomes	Routine	>30	3300 (for Nutrition & eating issue)
Episode End Date	The date when a patient/client no longer meets the criteria for a program/stream, and they cease to be a patient/client of the program/stream.	To facilitate cross sectional studies, to understand continuity of care and patient outcomes	Routine	N/A	3/08/2018
Contact Start Date	The date of the patient/client contact with a health service provider. This includes the health service provider's preparation time immediately prior to the contact.	To understand the patient journey in ambulatory care setting, to facilitate comparative ambulatory care services studies	Special	N/A	3/08/2018
Contact Program Stream	The program/stream for the Specialist Clinic (Outpatient) that is providing services for a particular contact.	To understand the patient journey in ambulatory care setting, to facilitate comparative ambulatory care services studies	Special	>30	114 (for Infectious Diseases)
Contact Professional Group	The professional group or professional(s) providing services for a contact.	To understand the patient journey in ambulatory care setting, to facilitate comparative ambulatory care services studies	Special	>70	272401 (for Physiotherapist)
Contact Purpose	The purpose of the service provided within the contact.	To understand the patient journey in ambulatory care setting, to facilitate comparative ambulatory care services studies	Special	>15	61 (for Research/Medical) 13 (for Specialist assessment)
Contact delivery setting	The type of setting in which the contact is experienced by the patient/client.	To monitor and plan health service utilisation	Special	>15	11 (for Inpatient setting)
Contact Inpatient Flag	An indication of whether the patient/client is an inpatient at the time of the contact.	To understand the patient journey within the hospital	Special	2	1 (for Inpatient/Admitted)
Contact duration	The duration of the patient/client contact in mins with a health service provider. This includes the health service provider's time to write case notes immediately after the contact.	To understand the patient journey in ambulatory care setting, to facilitate comparative ambulatory care services studies	Special	N/A	78

National Centre for Healthy Ageing (NCHA) Data Platform - Pharmacy Core Data Items

NOTE: The 'Special' core data item will require justification for data access

Core Data Item	Definition	Rationale	Core Data item type	Number of available drop down options	Example Data
Date of Medication Order	Date on which an order for medication, therapy or therapeutic device given by a properly authorised person, which ultimately goes to a person properly authorised to dispense, supply or perform the order (in most situations, a pharmacist) was raised	To facilitate the prediction of health outcomes along with other datasets such as inpatients, Optimising medication use, preventing adverse drug events	Routine	N/A	3/08/2018
Medication order type	Describes medication order type	To facilitate the prediction of health outcomes along with other datasets such as inpatients, Optimising medication use, preventing adverse drug events	Routine	3	<i>Intermittent (for Intermittent IV order)</i>
Drug Type	The type of medicinal product prescribed as represented by a code	Problems related to medications, adverse drug reactions in acute care, subacute care and ambulatory care and medication relevant interventions research	Routine	>15	<i>IP (for Chemotherapy)</i>
Medication Name	Name of the medication	Problems related to medications, adverse drug reactions in acute care, subacute care and ambulatory care and medication relevant interventions research	Routine	N/A	<i>acetaminophin</i>
Medication Dosage	The defined amount, strength, and quantity for a medication.	Medication safety studies, adverse drug reactions, prevention of medication errors such as the interval of administration of antibiotics, high-risk medication dilution, infusion-rate errors and errors in the administration of medications via nasogastric tubes.	Routine	N/A	<i>325 mg / 1 tablet</i>
Medication Route	Start date of the administration schedule	Medication safety studies, adverse drug reactions, prevention of medication errors such as the interval of administration of antibiotics, high-risk medication dilution, infusion-rate errors and errors in the administration of medications via nasogastric tubes.	Routine	5	<i>Oral</i>
Clinician specialty	The major field of specialty of the authorised health professional responsible for the medication order for a medicinal product as represented by a code	Medication safety studies, adverse drug reactions, prevention of medication errors such as the interval of administration of antibiotics, high-risk medication dilution, infusion-rate errors and errors in the administration of medications via nasogastric tubes.	Special	>50	<i>0203 (for Cardiology specialist)</i>
Date of supply	Date on which the medicine was supplied/dispensed by the pharmacy or hospital	Medication safety studies, adverse drug reactions, prevention of medication errors such as the interval of administration of antibiotics, high-risk medication dilution, infusion-rate errors and errors in the administration of medications via nasogastric tubes.	Special	N/A	3/08/2018
Pharmacy identifier	A unique, scrambled number identifying the dispensing pharmacy	To facilitate the required linkages	Special	N/A	1234567
Patient Identifier	A unique, scrambled number identifying the linked patient	To facilitate the required linkages	Special	N/A	1234567

National Centre for Healthy Ageing (NCHA) Data Platform - Pathology Core Data Items

NOTE: The 'Special' core data item will require justification for data access

Core Data Item	Definition	Rationale	Core Data item type	Number of available drop down options	Example Data
Patient type	Patient's encounter category	To facilitate the prediction of health outcomes along with other datasets such as inpatients and ambulatory care	Routine	>3	<i>Inpatient</i>
Order Date	The original order date and time for this order	Pathology information facilitates diagnostics, treatment decisions and research in enhancing quality of service to the patients	Routine	N/A	<i>3/08/2018</i>
Test name	The name of the test	Pathology information facilitates diagnostics, treatment decisions and research in enhancing quality of service to the patients	Routine	>30	<i>FBE</i>
Reason for test	Reason for this current test	Pathology information facilitates diagnostics, treatment decisions and research in enhancing quality of service to the patients	Routine	N/A	<i>Full blood count</i>
Specimen type	The type of specimen to be collected for testing	Pathology information facilitates diagnostics, treatment decisions and research in enhancing quality of service to the patients	Routine	>3	<i>Blood</i>
Order status	Status of the order	Pathology information facilitates diagnostics, treatment decisions and research in enhancing quality of service to the patients	Routine	>10	<i>Completed</i>
Collection date	The sample collection date	Pathology information facilitates diagnostics, treatment decisions and research in enhancing quality of service to the patients	Special	N/A	<i>3/08/2018</i>
Test result	The outcome of the test	Pathology information facilitates diagnostics, treatment decisions and research in enhancing quality of service to the patients	Special	N/A	<i>8.9</i>
Upper limit	The upper limit of the test reference range	Pathology information facilitates diagnostics, treatment decisions and research in enhancing quality of service to the patients	Special	N/A	<i>7.2</i>
Lower limit	The lower limit of the test reference range	Pathology information facilitates diagnostics, treatment decisions and research in enhancing quality of service to the patients	Special	N/A	<i>3.4</i>

National Centre for Healthy Ageing (NCHA) Data Platform - Mental Health Core Data Items

NOTE: The 'Special' core data item will require justification for data access

Core Data Item	Definition	Rationale	Core Data item type	Number of available drop down options	Example Data
Episode Start Date	The date on which the episode of mental health care within that setting formally or statistically commences.	To facilitate understanding of mental health services utilisation.	Routine	N/A	23/01/2022
Episode End Date	The date on which the episode of mental health care within that setting is formally or statistically completed.	To facilitate understanding of mental health services utilisation.	Routine	N/A	23/08/2022
Program	The organisational service unit attached to a subcentre. Each program identifies a clinical function or service intervention performed by a team that relates directly to a funded activity.	To determine the nature of mental health services demand and support optimised interventions.	Routine	>10	<i>Intensive treatment</i>
Phase of Care	The prospective primary goal of treatment within the episode of care in terms of the recognised phases of mental health care.	To determine the nature of mental health services demand and support optimised interventions.	Routine	5	<i>Acute</i>
Triage Outcome	The standardised triage scale and expected service response.	To establish <ul style="list-style-type: none"> • the person's need for specialist mental health services • the level of risk to the person and/or others • the urgency of the response required from mental health or other services 	Routine	7	<i>A (for situations requiring immediate referral to emergency services)</i>
Primary Diagnosis	The diagnosis established to be major condition responsible for the episode of care or an attendance at the health care establishment.	To determine and support optimisation of mental health problems.	Routine	>50	<i>F538 (for Other mental and behavioural disorders)</i>
Other Diagnoses	Other conditions, complications or comorbidities and associated conditions treated or investigated during the relevant episode of care.	To determine the comorbidities of mental health service events and support optimised interventions.	Routine	>50	<i>F604 (for Histrionic personality disorder)</i>
Service Contact Start Date	The date the service was provided to the client (or other service recipient).	To identify the service profile to inform future service requirements.	Special	N/A	15/07/2022
Service Contact End Date	<i>The date the service was completed to the client (or other service recipient).</i>	To identify the service profile to inform future service requirements.	Special	N/A	23/08/2022

National Centre for Healthy Ageing (NCHA) Data Platform - Community Health Core Data Items

NOTE: The 'Special' core data item will require justification for data access

Core Data Item	Definition	Rationale	Core Data item type	Number of available drop down options	Example Data
Health Condition/s	The client's health condition or diagnosis (starting with the most severe condition)	To facilitate Epidemiological research To understand holistic patient care and hospital utilisation	Routine	>40	<i>Obesity</i>
Referral Date	The date of referral	To understand service utilisation for required period	Routine	N/A	<i>08/12/2020</i>
Referral In provider type	The provider type of the referral source	To understand service utilisation per the source of the referral	Routine	>40	<i>GP/Medical Practitioner</i>
Service stream	A unique 'service type' provided to a client	To facilitate activity	Routine	>10	<i>Dietetics</i>
Service presenting reason	The service professional's description of the client's reason for assessment or treatment	To identify any increased risk for specific diseases	Routine	>80	<i>Overweight & Obesity</i>
Service initial contact date	The date of first contact for provision of services for a client	To understand the duration of the service	Special	N/A	<i>20/12/2020</i>
Service end date	The date of first contact for provision of services for a client	To understand the duration of the service	Special	N/A	<i>08/09/2021</i>

National Centre for Healthy Ageing (NCHA) Data Platform - Radiology Core Data Items

NOTE: The 'Special' core data item will require justification for data access

Core Data Item	Definition	Rationale	Core Data item type	Number of available drop down options	Example Data
Request date	Date on which an order for radiology imaging given by a properly authorised person was raised	To gain insights into specific diseases and conditions imaging requirements pertaining to multiple disciplines such as including oncology, cardiology, neurology, orthopedics etc	Routine	N/A	08/12/2020
Modality	The different types of medical imaging techniques used to visualise the body for diagnostic and therapeutic purposes	To gain insights into specific diseases and conditions imaging requirements pertaining to multiple disciplines such as including oncology, cardiology, neurology, orthopedics etc	Routine	>6	CT
Procedure/Exam name	A medical imaging session to study one or more body parts that yields one or more views for diagnostic purposes	To understand the utilisation of radiology imaging	Routine	>30	CT CARDIAC ANGIOGRAM
Reason for exam	A concise description of the clinical reason or suspicion that led to the ordering of the imaging exam	To facilitate evaluation of radiographic examinations for clinical merit and appropriateness	Routine	N/A	Unstable angina
Order status	The status of the radiology imaging order after as posted in the database	To facilitate understanding of the scheduled/unscheduled radiology imaging orders	Routine	>5	In-progress
Technique	Includes information about the imaging modality used, the specific imaging parameters, and any additional details relevant to the acquisition of the images	To facilitate radiology imaging utilisation insights	Special	N/A	384-slice Dual Source cardiac-gated CT scan performed with intravenous contrast using retrospective gating
Conclusion	A concise summary and interpretation of the imaging findings	To facilitate radiology imaging utilisation insights	Special	N/A	Severe coronary artery disease